GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
MOVEMENT DISORDERS PA SUMMARY

Preferred	Non-Preferred
Austedo (deutetrabenazine)* Tetrabenazine generic*	Ingrezza (valbenazine)

*preferred but requires PA

LENGTH OF AUTHORIZATION: 3 months for initial; 1 year for renewal

NOTES:

- Austedo and tetrabenazine generic are preferred but require prior authorization (PA).

PA CRITERIA:

Tetrabenazine Generic

- Approvable for members 18 years of age or older with a diagnosis of chorea (involuntary movements) associated with Huntington disease (HD) when the medication is prescribed by or in consultation with a neurologist and the prescriber has reviewed the risks of the medication with the member.
- Approvable for members 18 years of age or older with a diagnosis of moderate to severe tardive dyskinesia (TD) caused by the use of a dopamine receptor blocking agent (i.e., antipsychotic, metoclopramide) when the medication is prescribed by or in consultation with a neurologist or psychiatrist and the member has experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with clonazepam or amantadine.

Austedo

- Approvable for members 18 years of age or older with a diagnosis of chorea (involuntary movements) associated with Huntington disease (HD) when the medication is prescribed by or in consultation with a neurologist and the prescriber has reviewed the risks of the medication with the member, and the member has experienced an inadequate response or intolerable side effect with tetrabenazine (Xenazine).
- Approvable for members 18 years of age or older with a diagnosis of moderate to severe tardive dyskinesia (TD) caused by the use of a dopamine receptor blocking agent (i.e., antipsychotic, metoclopramide) when the medication is prescribed by or in consultation with a neurologist or psychiatrist and the member has experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with clonazepam or amantadine.

Ingrezza

- Approvable for members 18 years of age or older with a diagnosis of moderate to severe tardive dyskinesia (TD) caused by the use of a dopamine receptor blocking agent (i.e., antipsychotic, metoclopramide) when the medication is prescribed by or in consultation with a neurologist or psychiatrist and the member has experienced an inadequate response,

allergies, contraindications, drug-drug interactions or intolerable side effects with clonazepam or amantadine and tetrabenazine (Xenazine) or deutetrabenazine (Austedo).

QLL CRITERIA:

Medication	QLL
Tetrabenazine 12.5 mg tablets	120 tablets per 30 days
Tetrabenazine 25 mg tablets	60 tablets per 30 days

- Up to 120 tablets per 30 days of the 25-mg strength is approvable for members that are intermediate or extensive CYP2D6 metabolizers.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.